emailed Validation letter 1/10/12

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 1-9-12
Amount $525.-

I. IDENTIFICATION

Name: Williamson ARH Nursing Facility

Address: 260 Hospital Drive

City/County/Zip: South Williamson, KY 41503

Telephone number: 606-237-1725

Administrator: Sonya Wasserman, RN BSN

Date facility operation began at current address: 06-28-1963

Date facility began operation under current owner: 06-28-1963

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	~~35~~	
Nursing Home		
Nursing Facility	35	35
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County	X Nonprofit	Partnership
City		X Corporation
X Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Appalachian Regional Healthcare, Inc.
222 Executive Drive, Suite 400
Lexington, KY 40533

RECEIVED
JAN 09 2012
OFFICE OF INSPECTOR GENERAL

(OVER)

PB

If facility owned or leased by a corporation, complete the following:

Name of corporation Appalachian Regional Healthcare, Inc.

Address of corporation 222 Executive Drive, Suite 400, Lexington, KY 40533

President or Chairman Jerry Haynes

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Jim A. Hatfield — CCEO — 1/6/2012

Signature of authorized representative | Title | Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)